

Sheila R. Cizauskas HIGHLY CONFIDENTIAL
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<p style="text-align: right;">94</p> <p>1 A. I don't know what the acronym stands for. 2 It's just one of those things that we use in a -- 3 you know, daily bases. 4 Q. Do you know what? 5 A. But it measures processes. For example, 6 administering aspirin after a heart attack at the 7 hospital, and it would measure how often that 8 happens at the hospital -- 9 Q. I see. 10 A. -- would be an example. It's managed 11 through our quality department. 12 Q. And the KHRQ you referred to -- did I say 13 that right? 14 A. A, as in apple, AHRQ. 15 Q. I see. What -- what is that -- well, 16 first of all, do you know what it stands for? 17 A. No. 18 Q. Okay. 19 A. I -- 20 Q. What does it seek to measure? 21 A. That measures outcomes. For example, 22 infection rate after surgery, pneumonia after</p>	<p style="text-align: right;">96</p> <p>1 structure. Let's talk about a typical physician 2 practice. Does BCBS always enter into one contract 3 with the practice and then individual contracts 4 with each doctor in that practice? 5 A. I don't know about always, but that's the 6 general model; that each individual physician has 7 their own individual contract. 8 Q. If each physician has their own contract, 9 what is the need for and what's contained in the 10 contract with the practice? 11 A. What do you mean by "practice"? 12 Q. Well, you said there -- there are 13 contracts with individual doctors, and then there's 14 another over-arching contract. What's that 15 over-arching contract? Who is in between? 16 A. That would be an over-arching contract 17 that governs a group of physicians or a group of 18 practices that are organized through some kind of a 19 centralized infrastructure organization that 20 negotiates on their behalf for incentives or risk. 21 Q. Are you thinking about an independent 22 practice association?</p>
<p style="text-align: right;">95</p> <p>1 surgery, those kinds of things. 2 Q. How long has the hospital incentive 3 program been in place? 4 A. Well, it's been in place at least three 5 years and -- and it was in place when I arrived. 6 It has been expanded since then. I don't know how 7 long before that. 8 Q. Does the hospital incentive program 9 pertain to inpatient care, outpatient care, or 10 both? 11 A. Inpatient care. 12 Q. Now, when you first came to BCBS of 13 Massachusetts, you mentioned that the proportion of 14 risk-based contracts with physicians versus 15 fee-for-service contracts was lower than what you 16 had seen previously at Harvard Pilgrim, right? 17 A. And when we say, "contracts," we have sort 18 of the over-arching contract that covers a lot of 19 physicians, and then there's contracts with each 20 physician under that. So, if we're counting them 21 up, the risk-based contracts are very few. 22 Q. Well, let's discuss that -- that</p>	<p style="text-align: right;">97</p> <p>1 A. That would be one example. 2 Q. What other examples are there? 3 A. An integrated network, a staff model 4 group, employed physicians. 5 Q. Okay. In each of those cases, would there 6 be one over-arching contract and then individual 7 contracts? 8 A. I don't know if that's always the case, 9 but generally, yes. 10 Q. Would that be the case even with the staff 11 model? 12 A. There would be -- I can't say if the 13 individuals sign a contract, but the individual 14 contract that governs the behaviors of individual 15 physicians would be part of that. 16 Q. In these situations are reimbursement 17 terms contained within the over-arching contracts 18 or within the physician-specific contracts? 19 A. The -- depends. I mean, the global 20 capitation would be a reimbursement methodology, 21 and there would be individual contracts that would 22 have fee schedules attached to the individual</p>

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<p style="text-align: right;">98</p> <p>1 contract, the general fee schedule, and then the</p> <p>2 over-arching would simply outline the risk terms or</p> <p>3 the incentive terms.</p> <p>4 Q. Well, you said that the global capitation</p> <p>5 would be a reimbursement methodology, and then</p> <p>6 there'd be individual fee schedules. Aren't those</p> <p>7 -- isn't it a one or the other?</p> <p>8 A. Yes. There would be -- a global</p> <p>9 capitation is one model, and then individual fee</p> <p>10 schedules with an over-arching risk or incentive</p> <p>11 contract would be another model.</p> <p>12 Q. Well, let's -- let's separate those out.</p> <p>13 Let's say first we're talking about a situation</p> <p>14 that involves capitation.</p> <p>15 A. (Witness nods.)</p> <p>16 Q. In that situation, will there be one</p> <p>17 capitation contract with, say, the IPA, and then</p> <p>18 individual contracts regarding capitation with the</p> <p>19 physicians that make it up?</p> <p>20 A. We wouldn't have a global capitation model</p> <p>21 with an IPA. It would be with a staff model.</p> <p>22 Q. What about in the fee-for-service side?</p>	<p style="text-align: right;">100</p> <p>1 guess, but that would be my -- I -- I'm thinking</p> <p>2 that it was less than what was at Harvard Pilgrim.</p> <p>3 Q. During the three years since you've been</p> <p>4 at BCBS of Massachusetts --</p> <p>5 A. Uh-huh.</p> <p>6 Q. -- from 2003 to 2006, what has the trend</p> <p>7 been in terms of relative use of risk sharing</p> <p>8 versus fee for service?</p> <p>9 A. The trend has been to move to performance</p> <p>10 incentives.</p> <p>11 Q. But performance incentives can apply to</p> <p>12 either type of contract, correct?</p> <p>13 A. I guess it depends on how you define</p> <p>14 "risk" versus "performance." In my mind, risk is</p> <p>15 -- there's a downside potential.</p> <p>16 Q. Well, let's leave aside for a moment the</p> <p>17 four incentive programs we discussed earlier --</p> <p>18 A. Uh-huh.</p> <p>19 Q. -- including the PCPIP, the GPIP, and</p> <p>20 others. What is -- how has the relative balance</p> <p>21 between fee-for-service arrangements with</p> <p>22 physicians --</p>
<p style="text-align: right;">99</p> <p>1 Would fee-for-service contracts be with</p> <p>2 over-arching umbrella organizations, or would they</p> <p>3 be with individual physicians?</p> <p>4 A. The fee for -- the individual physician</p> <p>5 contract would be linked to a fee schedule, and the</p> <p>6 over-arching contract would outline the risk or</p> <p>7 incentive terms.</p> <p>8 Q. Okay. Now, going back to what we were</p> <p>9 talking about earlier, in terms of -- let's look at</p> <p>10 it in terms of the total number of physicians with</p> <p>11 whom BCBS of Massachusetts has a contractual</p> <p>12 arrangement.</p> <p>13 A. Uh-huh.</p> <p>14 Q. At the time you first joined, what</p> <p>15 proportion of physicians had a risk-based</p> <p>16 reimbursement versus fee-for-service-based</p> <p>17 reimbursement?</p> <p>18 A. When I first joined, I don't know the --</p> <p>19 the number. I just know that it was -- it was less</p> <p>20 prevalent than at Harvard Pilgrim.</p> <p>21 Q. The majority were fee for service.</p> <p>22 A. I don't know, but that -- and I shouldn't</p>	<p style="text-align: right;">101</p> <p>1 A. Uh-huh.</p> <p>2 Q. -- versus risk arrangements -- in which I</p> <p>3 include global capitation and budgeted</p> <p>4 capitation -- changed over time during the time</p> <p>5 you've been there at BCBS of Massachusetts?</p> <p>6 MR. COCO: Objection.</p> <p>7 A. I'm just trying to think about -- of the</p> <p>8 different types of contracts that I have done and</p> <p>9 how that -- how that has changed. And if we're</p> <p>10 talking risk, I don't think that the risk element</p> <p>11 has grown significantly. Maybe a little bit, but</p> <p>12 not significantly.</p> <p>13 Q. So, has the relative proportion remained</p> <p>14 static during the three years you've been there?</p> <p>15 MR. COCO: Objection.</p> <p>16 A. I don't know, without doing a, you know,</p> <p>17 full analysis of where it was or where it is now.</p> <p>18 Q. Okay. Well, let me ask it another way</p> <p>19 then. Is it fair to say that you are not aware of</p> <p>20 any noticeable difference in the relative</p> <p>21 proportion of fee for service versus risk-based</p> <p>22 physician contracts over the last three years?</p>

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<p style="text-align: right;">102</p> <p>1 MR. COCO: Objection.</p> <p>2 A. How -- can you tell me how you define</p> <p>3 "risk," because I think that's where I'm getting a</p> <p>4 little bit hung up on --</p> <p>5 Q. Sure.</p> <p>6 A. -- your definition of "risk."</p> <p>7 Q. Sure. I'm differentiating between two</p> <p>8 types of reimbursement arrangements with providers.</p> <p>9 First type of reimbursement arrangement I'm</p> <p>10 thinking about is a fee-for-service arrangement</p> <p>11 where the physician renders a service to a member,</p> <p>12 then submits a bill for reimbursement, specifying</p> <p>13 what services he provided, what drugs he</p> <p>14 administered, if any, and then is reimbursed by</p> <p>15 reference to that particular submission.</p> <p>16 A. Uh-huh.</p> <p>17 Q. Okay. That's the first type of</p> <p>18 arrangement I'm referring to. The second type of</p> <p>19 arrangement I'm thinking of, which I'm referring to</p> <p>20 as the risk models, are -- are arrangements wherein</p> <p>21 compensation is not tied to specific claims</p> <p>22 submitted for specific services or drugs, but</p>	<p style="text-align: right;">104</p> <p>1 Q. Including drugs --</p> <p>2 A. Yes.</p> <p>3 Q. -- administered in office? How many</p> <p>4 contracts are you aware of or how many physician</p> <p>5 groups have contracts that provided for that type</p> <p>6 of inclusive capitation --</p> <p>7 A. What time frame are you talking about --</p> <p>8 Q. -- that BCBS of Massachusetts --</p> <p>9 A. -- today or --</p> <p>10 Q. During the time that you've been at the --</p> <p>11 A. The whole time period. So, it's sort of a</p> <p>12 moving target, because some have come in and some</p> <p>13 have gone out of that arrangement. So, in total,</p> <p>14 I'm aware of three, four -- well --</p> <p>15 Q. What are those three practices that had</p> <p>16 inclusive capitation arrangements, including where</p> <p>17 the drugs were administered in office?</p> <p>18 A. River Bend had been a capitated model and</p> <p>19 is now a fee-for-service model, and then HealthONE</p> <p>20 is a global capitated model, and Fallon Clinic. I</p> <p>21 believe that's all there is.</p> <p>22 Q. Is Fallon Clinic still a global capitation</p>
<p style="text-align: right;">103</p> <p>1 rather, where reimbursement is on a capitated level</p> <p>2 or another payment methodology other than fee for</p> <p>3 service.</p> <p>4 A. When you say on other payment method,</p> <p>5 capitated is one category which is very small --</p> <p>6 Q. Okay.</p> <p>7 A. -- and has remained so and may have shrunk</p> <p>8 a little bit. And what other methodology would</p> <p>9 you --</p> <p>10 Q. Well, let's do them one by one. So, in</p> <p>11 terms of the -- the proportion of contracts that</p> <p>12 are capitated, those have shrunk over time?</p> <p>13 A. There's one group that has moved to a fee</p> <p>14 for service that used to be capitated.</p> <p>15 Q. Okay. Now, the arrangements that are</p> <p>16 capitated -- that were capitated -- what -- did</p> <p>17 those capitation contracts include all medical</p> <p>18 benefits, including both services and drugs?</p> <p>19 MR. COCO: Objection.</p> <p>20 A. There are a couple of different capitation</p> <p>21 models. One model includes everything, includes</p> <p>22 all medical expenses.</p>	<p style="text-align: right;">105</p> <p>1 contract?</p> <p>2 A. It's a new capitation contract.</p> <p>3 Q. So, if I understand this correctly,</p> <p>4 Fallon's a new capitation contract, HealthONE has</p> <p>5 been and continues to be a global capitation</p> <p>6 contract, and River Bend was capitation but has now</p> <p>7 moved to fee for service.</p> <p>8 A. Correct.</p> <p>9 Q. Okay. Now, why did these three physician</p> <p>10 practices have global capitation arrangements</p> <p>11 versus the more common fee-for-service</p> <p>12 methodologies?</p> <p>13 MR. COCO: Objection.</p> <p>14 A. Why -- meaning from their perspective or</p> <p>15 why -- I don't know why.</p> <p>16 Q. Well, in the -- do you -- are these</p> <p>17 practices practices for which you have</p> <p>18 responsibility --</p> <p>19 A. Yes.</p> <p>20 Q. -- in terms of contracting?</p> <p>21 A. Uh-huh.</p> <p>22 Q. Okay. When you've -- when the time comes</p>

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<p style="text-align: right;">106</p> <p>1 to contract with them or did come to contract with</p> <p>2 them, did BCBS of Massachusetts suggest a global</p> <p>3 capitation model, or did the physician practices</p> <p>4 raise it?</p> <p>5 MR. COCO: Objection.</p> <p>6 A. That pre-dates my involvement with -- it</p> <p>7 -- I have maintained an existing contract, so the</p> <p>8 initiation of it predated me.</p> <p>9 Q. Do you have any --</p> <p>10 VIDEO OPERATOR: Excuse me, Counsel. We</p> <p>11 need to change the tape.</p> <p>12 MR. MANGI: Let's take a break now.</p> <p>13 VIDEO OPERATOR: The time is 11:53. This</p> <p>14 is the end of Tape 1. We're off the record.</p> <p>15 (Recess was taken.)</p> <p>16 VIDEO OPERATOR: The time is 12:07 p.m.</p> <p>17 This is Cassette 2 in the deposition of Sheila</p> <p>18 Cizauskas. We're on the record.</p> <p>19 Q. Now, before the break we were talking</p> <p>20 about River Bend, HealthONE, and Fallon Clinic, and</p> <p>21 three physician practices that at some point --</p> <p>22 some currently have capitation contracts that</p>	<p style="text-align: right;">108</p> <p>1 arrangements?</p> <p>2 MR. COCO: Objection.</p> <p>3 A. I couldn't say why.</p> <p>4 Q. Well, have you ever considered why it is</p> <p>5 that these three plans for which you've had</p> <p>6 responsibility are treated differently from the</p> <p>7 majority of other physician practices?</p> <p>8 MR. COCO: Objection.</p> <p>9 A. I can only say what I see as similarities</p> <p>10 between the three, but I can't say that those</p> <p>11 similarities would be the reason that they were</p> <p>12 treated differently.</p> <p>13 Q. What are the similarities that you see</p> <p>14 between the three?</p> <p>15 A. That they are staff model organizations</p> <p>16 with employed physicians.</p> <p>17 Q. Now, has the HealthONE contract come up</p> <p>18 for renewal at any point during your time at the</p> <p>19 company?</p> <p>20 A. The over-arching contract has not.</p> <p>21 Q. Has there been any discussion that you are</p> <p>22 aware of in relation to HealthONE regarding why</p>
<p style="text-align: right;">107</p> <p>1 include drugs, right?</p> <p>2 A. Correct.</p> <p>3 Q. Now, did all three of those entities first</p> <p>4 enter into capitated contracts with BCBS of</p> <p>5 Massachusetts prior to your arrival at the company?</p> <p>6 A. Fallon, the negotiation was in process</p> <p>7 when I arrived and was concluded while I was there,</p> <p>8 and then the capitation threshold was reached very</p> <p>9 recently.</p> <p>10 Q. With Fallon, do you have an understanding</p> <p>11 as to whether the use of a capitation arrangement</p> <p>12 was first suggested by Fallon or by BCBS of</p> <p>13 Massachusetts?</p> <p>14 A. I don't know.</p> <p>15 Q. Do you know what BCBS of Massachusetts'</p> <p>16 position is, generally speaking, towards the use of</p> <p>17 capitation arrangements -- global capitation</p> <p>18 arrangements?</p> <p>19 MR. COCO: Objection.</p> <p>20 A. I don't know a general position.</p> <p>21 Q. Did you have any understanding of why</p> <p>22 these three entities have global capitation</p>	<p style="text-align: right;">109</p> <p>1 they have a capitation arrangement versus a</p> <p>2 fee-for-service arrangement?</p> <p>3 A. Maybe I should clarify even with</p> <p>4 HealthONE. The capitation arrangement covers the</p> <p>5 HMO fully-insured business. They also have</p> <p>6 fee-for-service arrangements for other lines of</p> <p>7 business, self-insured, PPO, and indemnity.</p> <p>8 Q. What do you mean when you say it "covers</p> <p>9 the HMO fully-insured business"?</p> <p>10 A. That those are accounts that are fully</p> <p>11 insured rather than -- they're insured through Blue</p> <p>12 Cross rather than being self-insured, and it's an</p> <p>13 HMO product.</p> <p>14 Q. Now, River Bend, when did River Bend</p> <p>15 transition from a global capitation arrangement to</p> <p>16 a fee-for-service arrangement?</p> <p>17 A. Their fee-for-service arrangement was</p> <p>18 effective January 1st, '06.</p> <p>19 Q. Were you involved in the discussions</p> <p>20 around the issue of moving over from one</p> <p>21 methodology to another?</p> <p>22 A. Yes.</p>

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<p style="text-align: right;">110</p> <p>1 Q. When was the issue of transitioning River 2 Bend from one methodology to another first raised? 3 A. Maybe about a year ago. 4 Q. Okay. Who raised the issue? 5 A. They did. 6 Q. In what context did they raise the issue? 7 A. They were concerned about some outstanding 8 liability that they had and wanted to -- they 9 wanted to step out of that risk. 10 Q. Was the outstanding liability related to 11 the capitation contract? 12 A. Yes. 13 Q. What do you mean when you say, 14 "outstanding liability"? 15 A. Pre-dates my joining Blue Cross. The 16 outstanding liability dates back to the beginning 17 of the contract. So, a capitation would have been 18 paid without any -- any reduction for services that 19 happened outside of that capitation. And when the 20 -- when that kind of contract ends, there's this 21 tail of claims that had been paid on their behalf 22 that they don't have the capitation revenue to</p>	<p style="text-align: right;">112</p> <p>1 A. No. 2 Q. Okay. So, what happened? 3 A. So, they entered into a fee-for-service 4 contract with a reduction to their fee-for-service 5 payments that would, over time, repay the 6 liability. 7 Q. After the liability was paid, then their 8 fee-for-service rates would increase? 9 MR. COCO: Objection. 10 A. It's a -- it's a multi-year repayment, and 11 then we will enter into a new discussion with them. 12 Q. The idea is to enable them to pay that -- 13 that over time. 14 A. Yes. 15 Q. Okay. The fee-for-service methodology 16 that River Bend transitioned to, is that the same 17 methodology that BCBS uses generally with other 18 physician practices? 19 A. In terms of the payment methodology, claim 20 comes in, we pay a fee, yes. And then there's a -- 21 another dimension overlaying that, which -- which 22 would look at incentives around utilization.</p>
<p style="text-align: right;">111</p> <p>1 offset, you know, once that end date comes, and 2 they were concerned about that. 3 Q. Was that a regularly-occurring phenomenon? 4 A. I really -- I can't speak to the financial 5 mechanism and the -- the economics of it. 6 Q. Was there concern relating to a liability 7 that had been incurred at one specific point early 8 in the process, or was there concern relating to a 9 liability that was being incurred on an ongoing 10 basis? 11 MR. COCO: Objection. 12 A. I can't -- I don't know. I -- I know that 13 there was a liability occurred at the beginning of 14 the contract that wouldn't come due until the 15 contract ended. 16 Q. Did the transition to a fee-for-service 17 AWP-based methodology enable River Bend to escape 18 the liability that was previously incurred? 19 A. No. 20 Q. So, River Bend settled whatever amounts 21 were owed under the prior contract in the course of 22 transitioning to the new contract?</p>	<p style="text-align: right;">113</p> <p>1 Q. And there's also the unique adjustment to 2 account for the debt repayment. 3 A. Yes. 4 Q. Okay. Well, what methodology did BCBS 5 transition River Bend to in terms of reimbursing 6 for drugs administered in office? 7 A. Would just be a fee-for-service payment 8 methodology. 9 Q. And how would the fee be determined in 10 relation to drugs administered in office? 11 A. It would be consistent with our fee -- fee 12 schedule. 13 Q. 95 percent of AWP? 14 A. That's a -- that's part of the business 15 that I don't handle. 16 Q. Okay. Do you have an understanding as to 17 how BCBS of Massachusetts, generally speaking, 18 reimburses physicians for drugs administered in 19 their offices? 20 A. I don't. 21 Q. You have no understanding as to what 22 methodology is applied or how the numbers are</p>

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<p style="text-align: right;">114</p> <p>1 calculated?</p> <p>2 A. I have come to learn that it's an AWP</p> <p>3 methodology, but how that is calculated, I don't</p> <p>4 know.</p> <p>5 Q. When did you come to learn that it was an</p> <p>6 AWP-based methodology?</p> <p>7 A. Just recently when I asked the question,</p> <p>8 in the past month or so.</p> <p>9 Q. In what circumstances did you first --</p> <p>10 what led you to query the methodology that's used</p> <p>11 to reimburse physicians for drugs administered in</p> <p>12 office?</p> <p>13 A. When I heard about this litigation.</p> <p>14 Q. Prior to hearing about this litigation,</p> <p>15 were you familiar with average wholesale price?</p> <p>16 A. Yes.</p> <p>17 Q. When's the first time you heard of average</p> <p>18 wholesale price?</p> <p>19 A. When I worked for Harvard Pilgrim.</p> <p>20 Q. In what context did you hear about average</p> <p>21 wholesale price while at Harvard Pilgrim?</p> <p>22 A. Harvard Pilgrim did a hospital outpatient</p>	<p style="text-align: right;">116</p> <p>1 implemented?</p> <p>2 A. January 1st, 2006.</p> <p>3 Q. Did -- who at BCBS was responsible for</p> <p>4 dealing with River Bend as regards that transition?</p> <p>5 A. It was a team of people, including myself,</p> <p>6 my counterpart in the actuarial department, my boss</p> <p>7 at the time, Deb Devaux.</p> <p>8 Q. Who -- who was your counterpart in the</p> <p>9 actuarial department?</p> <p>10 A. Andreana Shanley.</p> <p>11 Q. And your boss at the time was who?</p> <p>12 A. Deb --</p> <p>13 Q. She was your boss at the time?</p> <p>14 A. No, Deb Devaux was my boss.</p> <p>15 Q. Deb Devaux. Okay. Anyone else?</p> <p>16 A. Person who works for me. It was -- it was</p> <p>17 -- Steve Moorehead was the contract leader, and</p> <p>18 someone who worked for Andreana, Peter Chenette,</p> <p>19 the analyst. So, it was a collaborative effort to</p> <p>20 develop a model that would satisfy them and work</p> <p>21 for us.</p> <p>22 Q. How long was it between the time that they</p>
<p style="text-align: right;">115</p> <p>1 fee schedule update and implemented an average</p> <p>2 wholesale price fee schedule for the hospital</p> <p>3 outpatient.</p> <p>4 Q. Was reimbursement for hospital outpatients</p> <p>5 at AWP, or was it a percentage off AWP?</p> <p>6 A. It was a percentage off AWP.</p> <p>7 Q. Do you know what the percentage was?</p> <p>8 A. At that time it was 95 percent.</p> <p>9 Q. Now, turning back to River Bend, do you --</p> <p>10 do you now understand that the methodology to which</p> <p>11 River Bend was transitioned is -- in relation to</p> <p>12 drugs administered in office -- is 95 percent of</p> <p>13 AWP?</p> <p>14 A. I don't know the percentage.</p> <p>15 Q. So, you're aware that the standard</p> <p>16 methodology is AWP based, but you don't know what</p> <p>17 the percentage off of it is?</p> <p>18 A. Yes.</p> <p>19 Q. You said the possibility of moving was</p> <p>20 first raised by River Bend about a year ago?</p> <p>21 A. Best I can recall.</p> <p>22 Q. When was the transition actually</p>	<p style="text-align: right;">117</p> <p>1 first -- that River Bend first raised the issue of</p> <p>2 transitioning and BCBS agreed to allow them to</p> <p>3 transition?</p> <p>4 A. It was agreed fairly early on. It was the</p> <p>5 development of, you know, what the replacement</p> <p>6 model would be that took the time.</p> <p>7 Q. Did anyone at BCBS raise any concerns or</p> <p>8 objections in 2005 when this was under discussion</p> <p>9 to River Bend moving to a payment methodology that</p> <p>10 was related to AWP?</p> <p>11 A. No, it was never mentioned.</p> <p>12 Q. Earlier in the day we talked a bit about</p> <p>13 specialty pharmacies in relation to your time at</p> <p>14 Harvard Pilgrim. Do you know whether or not BCBS</p> <p>15 of Massachusetts uses specialty pharmacies?</p> <p>16 A. I don't know.</p> <p>17 Q. Have you ever been involved in any</p> <p>18 consideration as to whether specialty pharmacies</p> <p>19 should be used or what the parameters of specialty</p> <p>20 pharmacy programs should be?</p> <p>21 A. No.</p> <p>22 Q. Throughout your career in the industry at</p>

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<p>1 the various places where you worked, did any of the 2 health plans you were employed for have staff model 3 HMOs? 4 A. Did the health plan contract with staff 5 model HMOs? 6 Q. No, actually own a staff model HMO of its 7 own. 8 A. Well, Harvard -- prior to the merger of 9 Harvard and Pilgrim, Harvard was Harvard Community 10 Health Plan, and they owned the staff model HMO, 11 but that was prior to my joining them. 12 Q. Any other health plans? 13 A. No. 14 Q. Do you know whether or not BCBS of 15 Massachusetts ever had a staff model HMO? 16 A. I don't know. 17 Q. Do you have any understanding as to what 18 Harvard Community Health Care paid to acquire drugs 19 for its staff model HMO? 20 A. I don't know. 21 Q. Do you have any understanding as to what 22 hospitals or physicians paid to acquire drugs?</p>	<p>1 Q. We spoke earlier about your understanding 2 of the fact that costs for different services will 3 vary from provider to provider. Do you recall that 4 testimony? 5 MR. COCO: Objection. 6 A. I recall it as it relates to hospitals. 7 Q. Okay. Let's talk now about drugs 8 specifically. When providers and hospitals acquire 9 drugs, do you have an understanding as to whether 10 they can get rebates or discounts on their drug 11 purchases? 12 MR. COCO: Objection. 13 A. I don't know. 14 Q. Do you have any understanding as to 15 whether all hospitals or providers buy drugs at the 16 same price, or do they get different prices in the 17 marketplace? 18 A. I don't know. 19 MR. COCO: Objection. 20 Q. Do you have an understanding as to whether 21 or not -- in reimbursing at a percentage of AWP for 22 drugs administered in office -- that BCBS of</p>
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<p>1 A. No. 2 Q. Okay. Do you have any understanding as to 3 whether the amounts they pay to acquire drugs are 4 linked to any particular benchmarks in any way? 5 A. When you say, "they," who -- 6 Q. Hospitals and providers. 7 MR. COCO: Objection. 8 A. No, I don't know. 9 Q. Have you ever heard of the term "wholesale 10 acquisition cost" or WAC? 11 A. I've heard the term. 12 Q. What's your understanding of what WAC is? 13 A. I don't -- I don't know what the term 14 references, but I have heard it. 15 Q. In what context have you heard WAC? In 16 what context have you heard WAC or WAC referred to? 17 A. Just some -- just in my day-to-day 18 business. I don't remember specifically, but I 19 have heard the term. 20 Q. Do you have any understanding as to what, 21 if any, relationship there is between WAC and AWP? 22 A. I don't know.</p>	<p>1 Massachusetts follows Medicare? 2 A. In the physician's office? 3 Q. Yeah. 4 A. I don't know. 5 Q. Okay. Do you have an understanding as to 6 whether there's any relationship between Medicare's 7 reimbursement rates for drugs and the rates that 8 BCBS of Massachusetts has set for drugs? 9 MR. COCO: Objection. 10 A. I don't know. I mean, if -- I don't know 11 if Medicare is using AWP. 12 Q. Do you know whether or not Medicare has 13 ever used AWP in that context? 14 A. I believe so. 15 Q. Are you familiar with the term "ASP"? 16 A. I have heard the term. 17 Q. Okay. What's your understanding of ASP? 18 A. I believe it stands for average sale 19 price. 20 Q. Okay. Do you know what the ASP represents 21 for any given drug? 22 A. No.</p>

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<p style="text-align: right;">122</p> <p>1 Q. Do you have any understanding as to what 2 the relationship is, if any, between ASP and AWP? 3 A. No. 4 Q. Do you understand those to be different 5 numbers? 6 A. Yes. 7 Q. So, you understand that if we're talking 8 about any given drug, the ASP will be an entirely 9 different number from the AWP for that drug. 10 MR. COCO: Objection. 11 A. I don't know that to be true in every case 12 or any case. 13 Q. Well, when you said earlier that you 14 understood the ASP to be different from AWP, what 15 did you mean? 16 A. I mean that it's a different frame of 17 reference, but I don't know that the actual price 18 is different in every case or any case or all 19 cases. 20 Q. But you understand it's a different 21 benchmark? 22 A. Yes.</p>	<p style="text-align: right;">124</p> <p>1 set up a fee schedule for hospital outpatient 2 department drugs? 3 A. It was effective October 1st, 2005 for a 4 small subset of hospitals. 5 Q. Prior to October 1st, 2005, how had BCBS 6 of Massachusetts reimbursed hospital outpatient 7 departments in relation to drugs administered to 8 members? 9 A. As a percent of charges. It was paid on a 10 percent-of-charges basis. 11 Q. Was the percent of charges static, or did 12 it vary from contract to contract? 13 A. It was a negotiated percent by contract. 14 Q. So, prior to October 1st, 2005, all 15 hospital outpatient departments were reimbursed in 16 relation to drugs administered to members at a 17 percentage of bill charge, but the percentage 18 varied from contract to contract. 19 A. Correct. 20 Q. After October 1st, 2005, did some 21 hospitals transition to the new fee schedule or all 22 hospitals?</p>
<p style="text-align: right;">123</p> <p>1 Q. Do you know whether BCBS of Massachusetts 2 ever considered shifting to an ASP-based 3 methodology with regards to drugs administered in 4 physicians' offices? 5 A. I don't have any knowledge of decisions 6 for physicians' offices. 7 Q. Are you aware of contemplation of shifting 8 to an ASP-based methodology in any other 9 circumstances? 10 A. It was offered as a potential methodology 11 in the development of a hospital outpatient fee 12 schedule. 13 Q. When you say it was offered, what do you 14 mean by that? 15 A. When we decided to establish a fee 16 schedule for drugs at the -- in the hospital 17 outpatient setting, it was one methodology that was 18 offered late in the -- in the process. We had 19 already done a lot of work and came to a different 20 methodology, but that had been offered as a 21 suggestion late in the process. 22 Q. Now, when did BCBS of Massachusetts first</p>	<p style="text-align: right;">125</p> <p>1 A. Only the hospitals that were up for 2 renewal at that point. 3 Q. Now, how many hospitals were up for 4 renewal at that point? 5 A. I don't know exactly. Each year, 6 generally, a third of our network is up for 7 renewal. 8 Q. Is it contemplated that as more hospital 9 outpatient department-related contracts come up for 10 renewal BCBS will seek to transition them also from 11 a percentage of charge-based methodology to the new 12 fee schedule? 13 A. Yes. 14 Q. What is the methodology utilized in the 15 new fee schedule in relation to reimbursing 16 hospital outpatient departments for drugs 17 administered to members? 18 A. It's a percent of AWP. 19 Q. What is the percent of AWP in question? 20 A. 95 percent. 21 Q. So, BCBS of Massachusetts has made a 22 purposeful decision that it wants to transition</p>

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<p style="text-align: right;">126</p> <p>1 hospital outpatient departments from a 2 percent-of-charge basis -- in relation to drugs 3 administered to members -- to an AWP-based 4 methodology -- 5 MR. COCO: Objection. 6 Q. -- is that correct? 7 A. It's a conscious decision to transition 8 from percent of charge -- which is unpredictable 9 and dependent upon the hospital's setting of their 10 charges -- to a more predictable methodology that 11 has -- that has an industry understanding or an 12 industry standard. 13 Q. And that's AWP. 14 MR. COCO: Objection. 15 A. And that is -- that was the AWP fee 16 schedule. 17 Q. When was the question of setting up a fee 18 schedule for hospital outpatient departments first 19 raised? 20 A. It was raised in maybe the winter of 2003. 21 Q. And who raised that topic for the first 22 time?</p>	<p style="text-align: right;">128</p> <p>1 Work Group, and what did they then do? 2 A. They agreed that it was something to 3 study, and a -- and a team was commissioned, and 4 through that team, a phased-in approach to a new 5 outpatient fee schedule methodology was developed. 6 Q. Now, who was on the team that was 7 commissioned to study this issue by the Provider 8 Financial Strategy Work Group? 9 A. I don't remember the people's names, but 10 they represented cross-functional areas of the 11 organization that included claims IT, finance, 12 contracting -- the first phase of the team included 13 someone from our pharmacy area and payment 14 policies. 15 Q. Do you recall the names of any of the 16 individuals who were on that committee? 17 A. Myself, Terrence Driscoll, who worked in 18 finance at the time -- he has since transitioned to 19 my team -- Tom Kowalski, Mark Pruesar, Carlene 20 Fournier. 21 Q. I'm sorry. As you list these people -- 22 A. Yeah.</p>
<p style="text-align: right;">127</p> <p>1 A. I don't know for the first time, but I 2 raised the question of how much was -- how much of 3 our hospital reimbursement was being paid at a 4 percent of charges and asked to commission a group 5 to look at how to update that to a -- to fee 6 schedules where appropriate. 7 Q. Who did you raise this issue with? 8 A. My boss. 9 Q. And who was your boss at that time? 10 A. Deb Devaux and a group of leaders that -- 11 well, she brought that to a group of other leaders 12 in the organization, and a group was commissioned 13 to study it. 14 Q. Now, the group of leaders that she took 15 the proposal to -- took your proposal to -- does 16 that group go by any particular name? 17 A. PFSW. 18 Q. That's the Provider Financial Strategy? 19 A. Provider Financial Strategy -- yeah. 20 Yeah. 21 Q. So, you took the proposal to Deb Devaux; 22 she took it to the Provider Financial Strategies</p>	<p style="text-align: right;">129</p> <p>1 Q. -- could you also describe what of the -- 2 which of the cross-functional areas you described 3 earlier they come from? 4 A. Mark Pruesar came from actuarial. Tom 5 Kowalski came from pharmacy. John Killion came 6 from ancillary contracting. Some of these people 7 came in and out of the team as necessary. 8 Q. Was Mr. Killion a consistent member of the 9 team? 10 A. No, he was -- came to a few meetings. 11 Q. Anyone else that you recall? 12 A. Some of the people were on the phone, so I 13 can't even picture their faces, but they were from 14 the operational areas -- claims IT and payment 15 policies. 16 Q. When was this -- well, withdraw that. You 17 first raised the issue with Ms. Devaux in winter of 18 2003, right? 19 A. Yes. 20 Q. Okay. When did the provider -- and she 21 then took it to the Provider Financial Strategies 22 Work Group?</p>

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<p style="text-align: right;">130</p> <p>1 A. Uh-huh.</p> <p>2 Q. When did the Provider Financial Strategies</p> <p>3 Work Group commission the team we've been</p> <p>4 discussing to analyze the issue?</p> <p>5 MR. COCO: Objection.</p> <p>6 A. I don't know exactly, and there is a team</p> <p>7 that's still in place dealing with -- you know,</p> <p>8 this whole issue is, the work isn't completed yet.</p> <p>9 So, I would say it probably started in the spring</p> <p>10 of '04 -- let's see. We implemented it in October</p> <p>11 of '05. So, actually, you know, it actually sort</p> <p>12 of fell through the cracks over time and probably</p> <p>13 didn't start until either late '04 or early '05.</p> <p>14 Probably the winter of '04.</p> <p>15 Q. So, if I understand the chronology, you</p> <p>16 first raised it in the winter of '03; the Provider</p> <p>17 Financial Strategy Work Group commissioned a team</p> <p>18 in spring of '04; that team started work in late</p> <p>19 '04, and the shift to an AWP-based methodology was</p> <p>20 implemented starting in October of '05.</p> <p>21 MR. COCO: Objection.</p> <p>22 A. The piece of -- the spring of '04, I'm --</p>	<p style="text-align: right;">132</p> <p>1 Q. What sort of analysis did the Hospital</p> <p>2 Outpatient Department Fee Schedule Group carry out</p> <p>3 between the time it was commissioned in 2004 and</p> <p>4 the implementation in October of 2005?</p> <p>5 A. First step was to -- to see what was --</p> <p>6 what types of services were falling in the percent</p> <p>7 of charges -- or PAF bucket -- and how much we were</p> <p>8 paying from that percent of charge bucket, and then</p> <p>9 how that all -- how that all was bucketed into the</p> <p>10 service categories.</p> <p>11 Q. After that analysis was performed, what</p> <p>12 else did the hospital OPD fee schedule group study?</p> <p>13 A. We looked at the Medicare methodology of</p> <p>14 payment, APCs or APGs, I forget which one it is,</p> <p>15 and quickly determined that our systems could not</p> <p>16 accommodate that methodology and tried to find a</p> <p>17 rational approach to move as much out of the</p> <p>18 percent-of-charge category into an established fee</p> <p>19 schedule.</p> <p>20 Q. Any other analysis that was performed</p> <p>21 during that approximately year, year and a half</p> <p>22 period?</p>
<p style="text-align: right;">131</p> <p>1 I'm not sure that's when the PFSW commissioned, but</p> <p>2 the work began winter of '04.</p> <p>3 Q. Could it have been later in the -- in the</p> <p>4 year when the Provider Financial Strategy Work</p> <p>5 Group --</p> <p>6 A. Yes.</p> <p>7 Q. -- commissioned it?</p> <p>8 A. Yeah.</p> <p>9 Q. So, spring or summer of '04 is when the</p> <p>10 team was commissioned?</p> <p>11 A. I don't remember it being sort of a</p> <p>12 ceremonial occasion. So, it just finally, you</p> <p>13 know, was agreed that we should study it, and then</p> <p>14 sometime shortly after, we brought people together.</p> <p>15 Q. Now, in the course of -- withdraw that.</p> <p>16 The team that was analyzing this issue,</p> <p>17 cross-functional team --</p> <p>18 A. Uh-huh.</p> <p>19 Q. -- was it given any particular name or</p> <p>20 designation?</p> <p>21 A. It's the Hospital Outpatient Fee Schedule</p> <p>22 Group.</p>	<p style="text-align: right;">133</p> <p>1 A. As we began to decide, you know, to phase</p> <p>2 in the implementation of different portions of that</p> <p>3 PAF bucket, we -- we first decided to implement the</p> <p>4 AWP fee schedule for renewal hospitals. And so, we</p> <p>5 began to look at the renewal hospitals specifically</p> <p>6 in that category.</p> <p>7 Q. By that you mean you started to look at</p> <p>8 the order in which contracts would come up for</p> <p>9 renewal?</p> <p>10 A. Who the hospitals were, and how much was</p> <p>11 being paid on a percent of charges in that category</p> <p>12 for each hospital.</p> <p>13 Q. Did the group analyze what was being paid</p> <p>14 for drugs administered to patients in hospital</p> <p>15 outpatient departments under the percent-of-charge</p> <p>16 methodology?</p> <p>17 A. Uh-huh. Yes.</p> <p>18 Q. And did the group compare that to what</p> <p>19 would be paid under an AWP-based methodology?</p> <p>20 A. Yes.</p> <p>21 Q. What was the finding that resulted from</p> <p>22 that comparison?</p>

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<p style="text-align: right;">134</p> <p>1 A. It was different for each hospital.</p> <p>2 Q. Were there circumstances in which payment</p> <p>3 on an AWP-based methodology would be more cost</p> <p>4 effective for Blue Cross Blue Shield of</p> <p>5 Massachusetts?</p> <p>6 A. There were cases where the AWP methodology</p> <p>7 would pay less than the percent-of-charge</p> <p>8 methodology in isolation. So -- and then there</p> <p>9 were also cases where the AWP methodology would pay</p> <p>10 more than the percent-of-charges methodology.</p> <p>11 Q. Would you have an understanding as to in</p> <p>12 what proportion of cases AWP would result in lower</p> <p>13 payment versus higher payment?</p> <p>14 MR. COCO: Objection.</p> <p>15 A. What percentage of cases? You mean</p> <p>16 hospitals?</p> <p>17 Q. Uh-huh.</p> <p>18 MR. COCO: Objection.</p> <p>19 A. How many hospitals -- you're asking me how</p> <p>20 many hospitals resulted in --</p> <p>21 Q. Well, let me -- let me rephrase the</p> <p>22 question. Was the analysis in relation to drugs</p>	<p style="text-align: right;">136</p> <p>1 the contracting department and was part of the</p> <p>2 negotiation in the renewal.</p> <p>3 Q. Did you find that for -- since the</p> <p>4 analysis was on a hospital-by-hospital basis, at</p> <p>5 specific hospitals, was there variation as to</p> <p>6 whether AWP-based billing for drugs, you know,</p> <p>7 would be higher than bill charges for some drugs</p> <p>8 and lower than bill charges for other drugs?</p> <p>9 MR. COCO: Objection.</p> <p>10 A. We didn't look at a drug-by-drug analysis.</p> <p>11 It was overall.</p> <p>12 Q. Okay. So, on the basis of that overall</p> <p>13 analysis, was there any consistency as to whether</p> <p>14 AWP was higher or lower than bill charges for</p> <p>15 drugs?</p> <p>16 A. Some hospitals --</p> <p>17 MR. COCO: Objection.</p> <p>18 A. -- the AWP methodology paid more, and</p> <p>19 some hospitals the AWP methodology paid less.</p> <p>20 Q. Do you know what the relative proportion</p> <p>21 was of hospitals for which AWP resulted in higher</p> <p>22 payment versus lower payment?</p>
<p style="text-align: right;">135</p> <p>1 specifically carried out on a hospital-by-hospital</p> <p>2 level or a drug-by-drug level?</p> <p>3 A. Hospital-by-hospital level.</p> <p>4 Q. Okay. So, for any given hospital, the</p> <p>5 analysis that was performed was to look at what</p> <p>6 drugs were being billed for, how much was being</p> <p>7 paid for them on a percent-of-charge basis, and how</p> <p>8 much would be paid on an AWP basis?</p> <p>9 MR. COCO: Objection.</p> <p>10 Q. Is that correct?</p> <p>11 A. I'm not sure. If you could just say that</p> <p>12 again.</p> <p>13 Q. Sure.</p> <p>14 MR. MANGI: Would you mind rereading the</p> <p>15 question.</p> <p>16 (Question read back.)</p> <p>17 A. So, we looked at a hospital and all of the</p> <p>18 codes that would fall into an identifiable bucket</p> <p>19 of codes, how much was paid historically for that</p> <p>20 group of codes, and then we looked at how much</p> <p>21 would be paid if we paid 95 percent of AWP for that</p> <p>22 group of codes. And that number was provided to</p>	<p style="text-align: right;">137</p> <p>1 A. Fewer hospitals resulted in higher</p> <p>2 payment.</p> <p>3 Q. So, for the majority of hospitals, based</p> <p>4 on the analysis that BCBS of Massachusetts carried</p> <p>5 out in late '04 and '05, moving to an AWP-based</p> <p>6 methodology to reimburse for drugs administered in</p> <p>7 office --</p> <p>8 A. In hospital.</p> <p>9 Q. -- in hospitals, would result in a net</p> <p>10 saving.</p> <p>11 MR. COCO: Objection.</p> <p>12 A. Not necessarily, and if I could just</p> <p>13 expand a little bit, the -- it was a component of</p> <p>14 the negotiation of the renewal. And so,</p> <p>15 ultimately, the renewals ended up with higher rates</p> <p>16 overall for the hospital than prior to the renewal.</p> <p>17 Q. Well, I'd like to get to the negotiation a</p> <p>18 little later. For now I'm --</p> <p>19 A. Uh-huh.</p> <p>20 Q. -- focusing just on the analysis that was</p> <p>21 performed prior --</p> <p>22 A. Uh-huh.</p>

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<p style="text-align: right;">138</p> <p>1 Q. -- to the negotiation. I understood from 2 your testimony earlier that the analysis only 3 showed that -- and for the majority of hospitals 4 studied -- 5 A. Uh-huh. 6 Q. -- reimbursing at a percentage of AWP -- 7 95 percent of AWP -- would result in BCBS paying 8 less than it had been paying under the 9 percentage-of-bill-charge methodology. 10 MR. COCO: Objection. 11 Q. Is that correct? 12 A. The part that I'm struggling with is that 13 it would have generated a payment of less to Blue 14 Cross. What it generated was an analysis that 15 showed one methodology having higher level of cost 16 or payment -- if that were implemented -- than 17 another methodology. But then, we need to go to 18 the implementation, which -- 19 Q. I understand that. I'm talking only about 20 the analysis for the moment. 21 A. Uh-huh. Right. 22 Q. Not about what actually happened.</p>	<p style="text-align: right;">140</p> <p>1 A. Yes. 2 Q. Compared them to see whether -- if the 3 payment had been at 95 percent of AWP, would it 4 have permitted more or less than it actually did 5 using a percentage of bill charge? 6 A. Correct. 7 Q. And as a result of that analysis, BCBS 8 concluded that if it had made those payments based 9 on 95 percent of AWP, for the majority of 10 hospitals, it would have paid less in reimbursement 11 than it actually did using the 12 percentage-of-bill-charge methodology. 13 MR. COCO: Objection. 14 A. For the hospitals that were up for 15 renewal, which was a subset of all of the 16 hospitals, most of the hospitals, the AWP number 17 was lower than the percent-of-charge numbers. But 18 some hospitals, the AWP was higher than 19 percent-of-charge number. 20 Q. But based on that analysis, BCBS then 21 decided that it would seek to transition all 22 hospitals to an AWP-based methodology.</p>
<p style="text-align: right;">139</p> <p>1 A. So, it isn't -- I guess I'm struggling 2 with the word "savings," because that suggests that 3 there ended up being a savings. 4 Q. Let me try and rephrase it then without 5 using that word. 6 A. Okay. 7 Q. All right. In late 2004 and early 2005, I 8 understand from your testimony that BCBS of 9 Massachusetts analyzed the amounts it was paying to 10 -- it had paid historically to certain hospitals 11 for drugs that they administered in their hospital 12 outpatient departments, right? 13 A. (Nods.) Right. 14 Q. And those payment -- historic payments 15 that were being studied were a percentage of the 16 hospital's bill charges. 17 A. Correct. 18 Q. Okay. BCBS also then calculated what it 19 would have paid if those payments had, instead, 20 been paid on the basis of 95 percent of AWP. 21 A. Correct. 22 Q. And BCBS then compared those two numbers.</p>	<p style="text-align: right;">141</p> <p>1 A. No. 2 MR. COCO: Objection. 3 Q. Okay. Was a decision made to only seek to 4 transition those hospitals for which AWP resulted 5 in a savings -- would result in a savings compared 6 to bill charge? 7 MR. COCO: Objection. 8 A. No. You said that, based on the analysis, 9 Blue Cross made the decision to transition to AWP, 10 and that's not the case. The decision to 11 transition to AWP was based on having a standard 12 fee schedule. The analysis was intended to call to 13 our attention what that impact would be on the 14 hospital. 15 Q. I see. So, the analysis was one of the 16 factors that BCBS looked at in considering whether 17 or not to move all hospitals to an AWP-based 18 methodology. 19 A. No. 20 MR. COCO: Objection. 21 Q. It wasn't one factor that was looked at. 22 A. No.</p>

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<p style="text-align: right;">142</p> <p>1 MR. COCO: Objection.</p> <p>2 A. The analysis wasn't the factor in deciding</p> <p>3 to move to an AWP fee schedule. It was the</p> <p>4 standardization of having a fee schedule, rather</p> <p>5 than a percent of charge.</p> <p>6 Q. Okay. Well, I understand you're saying --</p> <p>7 you're saying the -- are you saying that the focal</p> <p>8 point in deciding to transition was the benefit of</p> <p>9 having a standardized fee schedule?</p> <p>10 A. Yes.</p> <p>11 Q. Now, I understand that that was the focal</p> <p>12 point, but didn't it also matter to BCBS -- wasn't</p> <p>13 it at all relevant to the decision that, for the</p> <p>14 majority of hospitals, it would also end up saving</p> <p>15 BCBS money?</p> <p>16 MR. COCO: Objection.</p> <p>17 A. No. It -- the -- the reason that Blue</p> <p>18 Cross was looking to transition to a standard fee</p> <p>19 schedule -- not just for drugs but for everything</p> <p>20 -- was the -- the predictability and the</p> <p>21 rationalization of a standard, rather than the</p> <p>22 inconsistency of charges that are set by the</p>	<p style="text-align: right;">144</p> <p>1 could offset changes in the reimbursement in</p> <p>2 another part of the fee schedule.</p> <p>3 MR. COCO: Objection.</p> <p>4 A. It was one component. It was one moving</p> <p>5 part in the entire negotiation of many moving</p> <p>6 parts. And so, it was one piece of a negotiation</p> <p>7 that included rates and performance measures and</p> <p>8 many components.</p> <p>9 Q. Well, was there any -- is there any</p> <p>10 negotiation with hospitals when they're making this</p> <p>11 transition as to the amount that will be reimbursed</p> <p>12 in relation to drugs that they administer in</p> <p>13 office?</p> <p>14 A. In the office?</p> <p>15 Q. I'm sorry. Withdraw that. When contracts</p> <p>16 with the hospitals are being negotiated --</p> <p>17 A. Uh-huh.</p> <p>18 Q. -- is there any negotiation around the</p> <p>19 amount that they will be reimbursed for drugs that</p> <p>20 are administered to members in the outpatient</p> <p>21 department?</p> <p>22 A. The contract negotiators are instructed to</p>
<p style="text-align: right;">143</p> <p>1 hospitals.</p> <p>2 Q. I understand that was the focal point.</p> <p>3 What I'm asking you is, wasn't it also relevant to</p> <p>4 the analysis and to the overall decision that</p> <p>5 moving to an AWP-based methodology for drugs would,</p> <p>6 for the majority of hospitals, result in a savings?</p> <p>7 A. No.</p> <p>8 MR. COCO: Objection. Asked and answered.</p> <p>9 Q. If that -- if that issue was -- if that</p> <p>10 issue was not at all relevant to the analysis, why</p> <p>11 did the Hospital Outpatient Department Fee Schedule</p> <p>12 Group make that comparison and perform that study?</p> <p>13 MR. COCO: Objection.</p> <p>14 A. Because when the negotiation occurred, the</p> <p>15 contract negotiators were given the -- the impact</p> <p>16 analysis to -- and that was available to them to</p> <p>17 redistribute in other areas of the contract so that</p> <p>18 the impact of the move to a standard fee schedule</p> <p>19 would be revenue neutral to the hospital.</p> <p>20 Q. So, in making that transition and</p> <p>21 negotiating the transition, BCBS recognized that</p> <p>22 changes in the amount of reimbursement in one area</p>	<p style="text-align: right;">145</p> <p>1 move every new renewal hospital to the standard fee</p> <p>2 schedule, and the negotiation would occur around</p> <p>3 the impact.</p> <p>4 Q. My question is, is there any negotiation</p> <p>5 regarding the specific methodology used to</p> <p>6 reimburse for drugs used in the hospital outpatient</p> <p>7 department, or is that a standard 95 percent of</p> <p>8 AWP?</p> <p>9 MR. COCO: Objection.</p> <p>10 A. It is an AW -- 95 percent of AWP is the</p> <p>11 new hospital outpatient fee schedule, and as</p> <p>12 hospitals come up for renewal, that will be the fee</p> <p>13 schedule that is -- that applies.</p> <p>14 Q. Is there any individualized variation from</p> <p>15 that 95 percent of AWP formula?</p> <p>16 A. There has not been till now -- up till</p> <p>17 now.</p> <p>18 Q. Is BCBS open to negotiating that part of</p> <p>19 the fee schedule, or is that an inflexible</p> <p>20 take-it-or-leave-it part of the contract</p> <p>21 negotiation process?</p> <p>22 MR. COCO: Objection.</p>

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<p style="text-align: right;">146</p> <p>1 A. That's a standard fee schedule. That is 2 -- has been implemented consistently with the 3 renewal hospitals. 4 Q. Am I correct in my understanding that BCBS 5 is now seeking to transition all hospital 6 outpatient departments to the new fee schedule? 7 A. As hospitals come up for renewal, it will 8 be one of the components of the negotiation, and 9 it's intended that they will be implemented on the 10 new fee schedule. 11 Q. When was the -- I understand that the 12 implementation of these -- of this change started 13 in October of '05, but when was the final decision 14 made by the Hospital Outpatient Department Fee 15 Schedule Group to proceed with the transition? 16 MR. COCO: Objection. 17 A. Probably the spring of '05. 18 Q. So, between spring and October, the 19 company was working on logistical issues associated 20 with making the transition? 21 A. Negotiations generally start with 22 hospitals in the spring and summer of the preceding</p>	<p style="text-align: right;">148</p> <p>1 process will be complete and all hospital 2 outpatient departments will have been transitioned 3 to AWP-based fee schedules. 4 MR. COCO: Objection. 5 A. If we continue in this manner, yes. But 6 there's been no decision that we wouldn't change to 7 another methodology. It's been decided for the 8 renewals in 10/1/06 to continue. 9 Q. Well, is there a -- when you said it's 10 anticipated it'll will take five years to do that, 11 is that a -- is that number -- how did you come up 12 with that number? 13 A. I'm just thinking about how long -- how 14 long we have with each contract. So, I'd say, 15 actually, it was probably five years at the time we 16 started this. Now it's probably four years. Our 17 longest contract out there is a five-year contract, 18 so that's what I'm thinking. 19 Q. So, the decision has been made on an 20 ongoing basis to continue to transition hospitals 21 to an AWP-based fee schedule for drugs administered 22 in outpatient departments as the contracts come up</p>
<p style="text-align: right;">147</p> <p>1 -- of the year that the new rates go in place. 2 Q. What proportion of hospital outpatient 3 departments have now been transitioned to the new 4 AWP-based fee schedule? 5 A. I don't know exactly, but I -- it's 6 between 25 and 30 percent of the hospitals. 7 Q. Have any hospitals thus far refused to 8 make the transition? 9 A. No. 10 Q. How long is it anticipated that it'll take 11 before all hospital outpatient departments have 12 been successfully transitioned to the new AWP-based 13 fee schedule? 14 A. Five years. 15 Q. So, BCBS of Massachusetts plans to 16 continue working to transition all hospitals to an 17 AWP-based fee schedule until that process is 18 completed in approximately 2011? 19 A. The decision has been made for the 20 renewals that are coming up for October of '06 to 21 include the AWP fee schedule in those renewals. 22 Q. And it's anticipated that by 2011, the</p>	<p style="text-align: right;">149</p> <p>1 for renewal, and based on the current rate of 2 progress, if there's no change in approach, you 3 anticipate that will take up until around 2011. 4 MR. COCO: Objection. 5 A. The decision has been made for the 6 renewals that are coming due this year to include 7 AWP fee schedule in those renewals. Each year the 8 -- all of the components to the hospital contract 9 are reviewed and decisions are made annually. 10 Q. Am I correct in understanding, though, 11 that in -- when a decision was made to proceed with 12 the transition, the decision was to try and proceed 13 with the transition for all hospitals, but to 14 stagger implementation as contracts came up for 15 renewal? 16 MR. COCO: Objection. 17 A. The decision is made on an annual basis of 18 how to handle the group of hospitals that are up 19 for renewal. And that's -- so, at this point, we 20 have the renewals that took place for 10/1/05, and 21 now the renewals that are coming due for 10/1/06 22 that we include AWP.</p>

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<p style="text-align: right;">150</p> <p>1 Q. So, in the spring of '05 -- withdraw that.</p> <p>2 Do I understand correctly that these contracts come</p> <p>3 up for renewal once a year?</p> <p>4 A. There are multi -- they're multi-year</p> <p>5 contracts, so there are some contracts that come up</p> <p>6 for renewal each year. It's not the same contract</p> <p>7 each year.</p> <p>8 Q. So, in the spring of 2005, a decision was</p> <p>9 made to implement the transition for all the</p> <p>10 contracts that were coming up for renewal later in</p> <p>11 '05.</p> <p>12 A. Correct.</p> <p>13 Q. And this year, in '06, a decision's been</p> <p>14 made to implement the transition to an AWP-based</p> <p>15 fee schedule for all contracts that are coming up</p> <p>16 for renewal in '06?</p> <p>17 A. Correct.</p> <p>18 MR. COCO: Objection.</p> <p>19 Q. And similarly, the decision for '07 will</p> <p>20 be made in early '07.</p> <p>21 A. Yes.</p> <p>22 Q. Okay. When --</p>	<p style="text-align: right;">152</p> <p>1 consensus decision.</p> <p>2 Q. Is the Hospital Outpatient Department Fee</p> <p>3 Schedule Group still in existence?</p> <p>4 A. Yes.</p> <p>5 Q. Is that the group which makes the</p> <p>6 decisions regarding transitioning hospitals to the</p> <p>7 new methodology?</p> <p>8 A. No.</p> <p>9 Q. Okay. Is that group tasked merely with</p> <p>10 the analytical and logistical work associated with</p> <p>11 making those changes?</p> <p>12 A. Yes.</p> <p>13 Q. So, who or which group is responsible for</p> <p>14 making the actual decision about transitions?</p> <p>15 A. PFSW.</p> <p>16 Q. So, in the spring of '05, when a decision</p> <p>17 was made to transition the contracts coming up for</p> <p>18 renewal in '05, that was a decision from the</p> <p>19 Provider Financial Strategies Group.</p> <p>20 A. The Provider Financial Strategy Group</p> <p>21 would be made aware of the overall contracting</p> <p>22 strategy each year, and unless there's an</p>
<p style="text-align: right;">151</p> <p>1 MR. COCO: When you get to a good breaking</p> <p>2 point.</p> <p>3 Q. When was the decision made regarding</p> <p>4 transitioning hospitals that are coming up for</p> <p>5 renewal in '06 to an AWP-based methodology?</p> <p>6 MR. COCO: Objection.</p> <p>7 A. When was the decision made for the '06</p> <p>8 hospitals?</p> <p>9 Q. Yeah.</p> <p>10 A. It was made in conjunction with the</p> <p>11 overall hospital contracting plan, and I would say</p> <p>12 that that was made early in '06.</p> <p>13 Q. In January or February of '06?</p> <p>14 A. I can't put a particular date. There was</p> <p>15 -- there was no decision made to deviate from the</p> <p>16 prior years' implementation.</p> <p>17 Q. Who made the decision regarding</p> <p>18 implementation of the transition to an AWP-based</p> <p>19 methodology for hospital outpatient departments in</p> <p>20 2006?</p> <p>21 MR. COCO: Objection.</p> <p>22 A. There is no single person. It's sort of a</p>	<p style="text-align: right;">153</p> <p>1 objection, that's the way contract strategy will be</p> <p>2 rolled out.</p> <p>3 Q. That's the body that provides the final</p> <p>4 approval?</p> <p>5 MR. COCO: Objection.</p> <p>6 A. It's not -- I -- I don't know of a stamp</p> <p>7 of approval, but that they are made aware of the</p> <p>8 strategy. And if there were an objection, they</p> <p>9 would make the objection.</p> <p>10 Q. And similarly, in the spring -- in --</p> <p>11 earlier in '06, the decision for the --</p> <p>12 transitioning the hospital outpatient department</p> <p>13 contracts coming up for renewal in '06 was</p> <p>14 presented to the Provider Financial Strategies Work</p> <p>15 Group?</p> <p>16 MR. COCO: Objection.</p> <p>17 A. I don't remember a formal presentation,</p> <p>18 but the group was made aware of the strategy</p> <p>19 overall, and there was no objection to it.</p> <p>20 MR. MANGI: This is a good time for lunch.</p> <p>21 VIDEO OPERATOR: The time is 1:04. We're</p> <p>22 off the record.</p>

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<p style="text-align: right;">154</p> <p>1 (Whereupon the deposition recessed at 2 1:04 p.m.)</p> <p>3</p> <p>4 AFTERNOON SESSION (2 p.m.)</p> <p>5 VIDEO OPERATOR: The time is 1:58. We're 6 on the record.</p> <p>7 Q. Ms. Cizauskas, before the break we were 8 talking about the Hospital Outpatient Department 9 Fee Schedule Group's work in '05 and -- well, '04, 10 '05, and '06.</p> <p>11 A. Uh-huh.</p> <p>12 Q. What documentation was generated as part 13 of the group's consideration of this issue?</p> <p>14 A. It was mostly analysis of the dollars in 15 play for each category of hospital outpatient that 16 falls into the percent-of-charges payment 17 methodology.</p> <p>18 Q. Was any analysis or documentation 19 generated other than financial analysis?</p> <p>20 A. Not that I recall. There may have been 21 minutes from the first meeting, although that -- 22 that group really didn't keep minutes. Some groups</p>	<p style="text-align: right;">156</p> <p>1 person or also by e-mail?</p> <p>2 A. The discussion was in a meeting, with some 3 people being there in person and others on the 4 phone.</p> <p>5 Q. Was there any -- were there any e-mails 6 exchanged among the group or between specific 7 members of the group discussing the issues 8 surrounding the work of the group?</p> <p>9 A. The e-mails would have been the Excel 10 spreadsheets that were generated as part of the 11 work.</p> <p>12 Q. Were there any other e-mails discussing 13 the spreadsheets or discussing other issues related 14 to the transition?</p> <p>15 A. The discussion generally happened in the 16 meetings with the spreadsheets as the basis for 17 discussion.</p> <p>18 Q. Was the overall analysis work of the group 19 summarized in documentary form for onward 20 transition to others in the company?</p> <p>21 A. There were high-level aggregate numbers 22 that were shared with others.</p>
<p style="text-align: right;">155</p> <p>1 do, but I don't believe that group did.</p> <p>2 Q. Were any Power Point presentations 3 generated in the course of that process?</p> <p>4 A. No.</p> <p>5 Q. Were any analytical memoranda generated in 6 the course of that process?</p> <p>7 MR. COCO: Objection.</p> <p>8 A. I don't remember any memoranda. It was a 9 working group, and so, there was exchange of data, 10 you know, as part of the working sessions.</p> <p>11 Q. How was the data exchanged or circulated?</p> <p>12 A. Power -- Excel spreadsheet would be shared 13 with the group.</p> <p>14 Q. Was that shared by e-mail or in hard copy?</p> <p>15 A. Both.</p> <p>16 Q. And that included spreadsheets we 17 discussed earlier, comparing bill -- 18 percentage-of-charge drug reimbursements to 19 AWP-based calculations.</p> <p>20 A. It included that and all other categories 21 in the percent of charge --</p> <p>22 Q. Did the group discuss these issues only in</p>	<p style="text-align: right;">157</p> <p>1 Q. Was that an Excel spreadsheet or a Power 2 Point presentation?</p> <p>3 A. It would have been an Excel spreadsheet. 4 I don't recall any Power Point presentations 5 associated with this group.</p> <p>6 Q. Who else at the company were those 7 spreadsheets shared with, other than people from 8 the group?</p> <p>9 A. The contract negotiators that were 10 negotiating the renewal contracts would have had 11 some subset of information as it related to their 12 individual contracts.</p> <p>13 Q. Anyone else?</p> <p>14 A. The finance area that supported the 15 contract negotiation.</p> <p>16 Q. Anyone else?</p> <p>17 A. At that level detail, no.</p> <p>18 Q. Was the work of the hospital OPD fee 19 schedule group memorialized in any way for 20 transition to the Provider Financial Strategies 21 Work Group?</p> <p>22 A. It -- what -- the recommendations that</p>

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<p style="text-align: right;">158</p> <p>1 were a product of that group were part of the 2 overall strategy that was presented. 3 Q. Were there any documents in which those 4 recommendations were memorialized for presentation 5 to the Provider Financial Strategies Work Group? 6 A. There was a strategy -- a strategy 7 document or the hospital contracting plan document 8 that was shared with the PFSW, and it included a 9 recommendation on the hospital outpatient. 10 Q. Who generated that contracting plan 11 document? 12 A. I did. 13 Q. Do you have a copy of that document in 14 your files? 15 A. I imagine so. I would have to find it and 16 look for it. 17 Q. In -- withdraw that. Have you been asked 18 to search your files for documents relevant to this 19 litigation? 20 A. Yes. 21 Q. Okay. Did you, in fact, search your files 22 for documents relevant to this litigation?</p>	<p style="text-align: right;">160</p> <p>1 from Ms. Cizauskas's files? 2 MR. COCO: My understanding is -- 3 MR. MANGI: Are -- what is the source of 4 these documents that were produced prior -- at the 5 deposition of this morning? 6 MR. COCO: Go ahead. 7 MR. SKWARA: I think they are from Ms. 8 Cizauskas's files. These would be on the CD as 9 well. These are the ones we've been able to print 10 so far. 11 MR. MANGI: Let's go off the record for a 12 second. 13 VIDEO OPERATOR: The time is 2:07. We're 14 off the record. 15 (Discussion off the record.) 16 VIDEO OPERATOR: The time is 2:08. We're 17 on the record. 18 MR. MANGI: While we were off the record, 19 Counsel clarified that Ms. Cizauskas has produced a 20 number of documents to counsel for BCBS of 21 Massachusetts prior to this deposition. A set of 22 documents was produced this morning, which is Bates</p>
<p style="text-align: right;">159</p> <p>1 A. Yes. 2 Q. When did you perform that search? 3 A. This week. Well, what's today? Friday. 4 So, it was this week. Early in the week. Monday, 5 I would say. 6 MR. MANGI: Let's mark as Exhibit Cizauskas 7 001 a set of documents. 8 (BCBSMA-AWP 13002-13011 marked 9 Exhibit Cizauskas 001.) 10 Q. Do you recognize the set of documents 11 that's been marked as Exhibit Cizauskas 001? 12 A. (Witness reviews document.) No. 13 Q. Are these the documents that you located 14 in your files when searching for documents relative 15 to this litigation? 16 A. No. 17 MR. COCO: For the record, Adeel, I do 18 have a CV I'm having -- that I got this week. I'm 19 having logistical issues trying to open the 20 documents and then examine them and get them to 21 you. 22 MR. MANGI: Is that the CD of documents</p>	<p style="text-align: right;">161</p> <p>1 numbered BCBSMA-AWP 13002 to 13011. Counsel has 2 represented that this is a subset of the complete 3 set of documents produced from Ms. Cizauskas' 4 files. The rest of the documents will be produced 5 after counsel has had an opportunity to review 6 them. For the record, Defendants reserve the right 7 to recall Ms. Cizauskas for deposition should that 8 prove necessary upon examination of her documents. 9 Q. When you searched your files for documents 10 relative to this litigation, what parameter did you 11 use? 12 A. Being not very technically savvy, I simply 13 did a search of my computer for anything that had 14 the reference "AWP." 15 Q. Did you search for anything beyond 16 documents that use the term "AWP"? 17 A. No. 18 Q. Were you directed to search only for the 19 words "AWP"? 20 A. That was my understanding of what I was 21 expected to do. 22 Q. Did you search your e-mails or also</p>

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<p style="text-align: right;">162</p> <p>1 electronic files on your computer?</p> <p>2 A. I searched my computer, and I'm -- I</p> <p>3 assume that it searched everything in my computer.</p> <p>4 Q. Well, how, logistically, did you carry out</p> <p>5 that search?</p> <p>6 A. I went to the Start menu and hit "Search,"</p> <p>7 and then put in the word "AWP," and asked it to</p> <p>8 search my computer.</p> <p>9 Q. Do you use Outlook as your e-mail program?</p> <p>10 A. Yes.</p> <p>11 Q. Do you maintain e-mails in folders --</p> <p>12 subfolders in your inbox in Outlook?</p> <p>13 A. Minimally.</p> <p>14 Q. Do you maintain e-mails within your inbox?</p> <p>15 A. Yes, I -- I go to -- get to capacity</p> <p>16 frequently.</p> <p>17 Q. Now, are you aware that a search from the</p> <p>18 Start menu of your computer will not search e-mails</p> <p>19 within Outlook?</p> <p>20 A. No.</p> <p>21 Q. Okay. Did you take any steps, other than</p> <p>22 what you've just described, to electronically</p>	<p style="text-align: right;">164</p> <p>1 described.</p> <p>2 Q. Did you search for the contracting plan</p> <p>3 document relating to the analysis of the Hospital</p> <p>4 Outpatient Department Fee Schedule Group that was</p> <p>5 presented to the Provider Financial Strategies Work</p> <p>6 Group?</p> <p>7 A. No.</p> <p>8 MR. MANGI: For the record, we ask that a</p> <p>9 diligent search be performed of Ms. Cizauskas'</p> <p>10 files. We'll follow that up by letter detailing</p> <p>11 the deficiencies.</p> <p>12 MR. COCO: I'll just object to your</p> <p>13 characterization of the search.</p> <p>14 Q. Now, when the decision was made to</p> <p>15 transition in the spring of '05 the hospital</p> <p>16 outpatient department contracts that were coming up</p> <p>17 for renewal in 2005, you testified earlier that the</p> <p>18 period from spring to October was devoted to</p> <p>19 preparation and logistical work, is that correct?</p> <p>20 A. Yes, and negotiations.</p> <p>21 Q. Okay. Leaving aside the negotiations for</p> <p>22 a moment, what sort of logistical work did that</p>
<p style="text-align: right;">163</p> <p>1 search your e-mails for relevant documents?</p> <p>2 A. No.</p> <p>3 Q. Did you search -- the search that you did</p> <p>4 run, do you have an understanding as to whether</p> <p>5 that searched only the names of files or whether it</p> <p>6 also searched for responsive text within files?</p> <p>7 A. I don't know.</p> <p>8 Q. Okay. Did you take any steps to search</p> <p>9 your hard copy files?</p> <p>10 A. No.</p> <p>11 Q. Did you search your files for documents</p> <p>12 dealing with the work of the Hospital Outpatient</p> <p>13 Department Fee Schedule Group?</p> <p>14 A. I -- the product of the search I did</p> <p>15 produced the spreadsheets that were used in that</p> <p>16 group.</p> <p>17 Q. But did you search specifically for all</p> <p>18 documents associated with the work of the Hospital</p> <p>19 Outpatient Department Fee Schedule Group,</p> <p>20 regardless of whether "AWP" was in the title of the</p> <p>21 specific document?</p> <p>22 A. I searched with the parameters that I</p>	<p style="text-align: right;">165</p> <p>1 transition entail?</p> <p>2 A. Analyzing each hospital's impact --</p> <p>3 financial impact -- between their historical</p> <p>4 percent of charge and the AWP fee schedule.</p> <p>5 Q. And that was in preparation for</p> <p>6 negotiating with the --</p> <p>7 A. Yes.</p> <p>8 Q. -- hospital, correct? Was work performed</p> <p>9 with reference to the claims processing systems and</p> <p>10 fee schedules to transition those systems in</p> <p>11 preparation for the move to AWP-based</p> <p>12 reimbursement?</p> <p>13 A. There was work by the departments that</p> <p>14 handle fee schedule implementation to test to make</p> <p>15 sure that the fee schedule was implemented</p> <p>16 properly.</p> <p>17 Q. Do you know how long it took to implement</p> <p>18 the fee schedule transition?</p> <p>19 A. No.</p> <p>20 Q. Is it fair to say it was done in that</p> <p>21 period -- somewhere in that period, from spring to</p> <p>22 October of '05?</p>

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<p style="text-align: right;">166</p> <p>1 A. Yes.</p> <p>2 Q. Are you aware of any problems that came up</p> <p>3 in making the transition at the claims or</p> <p>4 fee-schedule level?</p> <p>5 A. I'm not aware of any problems.</p> <p>6 Q. Do you know whether work on the fee</p> <p>7 schedule and claims processing systems continued</p> <p>8 from spring all the way through to October</p> <p>9 continuously, or was there a specific period of</p> <p>10 time within that window when this work was</p> <p>11 performed?</p> <p>12 A. It was parallel work that was done outside</p> <p>13 of the team effort, and all I know is that we</p> <p>14 needed it to be ready for implementation on October</p> <p>15 1st, and it was.</p> <p>16 Q. Okay. Are you familiar with the</p> <p>17 outpatient prospective payment system, or OPPTS?</p> <p>18 A. Not characterized by those initials, but</p> <p>19 if you mean, like, APG or APC system, yes.</p> <p>20 Q. So, you're familiar with APCs, which are</p> <p>21 ambulatory patient classifications?</p> <p>22 A. Yes.</p>	<p style="text-align: right;">168</p> <p>1 outpatient departments for drugs administered to</p> <p>2 patients?</p> <p>3 A. Yes.</p> <p>4 Q. What consideration was given to that</p> <p>5 issue?</p> <p>6 A. We spoke with a consultant who gave a</p> <p>7 description of what Medicare was doing and</p> <p>8 consulted internally with our operations department</p> <p>9 to understand whether it was feasible, from an</p> <p>10 operational perspective, to implement that type of</p> <p>11 a methodology, and it was quickly determined that</p> <p>12 -- that it was not feasible with -- from an</p> <p>13 operational perspective at this point in time.</p> <p>14 Q. Who was the consultant that you spoke to?</p> <p>15 A. Treo Systems.</p> <p>16 Q. Will you spell that.</p> <p>17 A. I don't remember it. T-r-e-o.</p> <p>18 Q. Treo Systems?</p> <p>19 A. Yeah. Oh, I'm sorry. Treo Solutions.</p> <p>20 Q. Was there a particular individual or</p> <p>21 individuals at Treo Solutions who your group</p> <p>22 consulted with?</p>
<p style="text-align: right;">167</p> <p>1 Q. What is your understanding of what an APC</p> <p>2 is?</p> <p>3 A. My understanding is very limited in that</p> <p>4 it's a group -- a grouping characterization of --</p> <p>5 of services administered on the outpatient that are</p> <p>6 paid with a single payment for a group, similar to</p> <p>7 the inpatient DRG, but that's the extent of my</p> <p>8 knowledge.</p> <p>9 Q. You also referred to an APG. What is an</p> <p>10 APG?</p> <p>11 A. Right. It's my understanding that one of</p> <p>12 -- one -- and I don't remember which is which --</p> <p>13 one was used by Medicare, and one was used by</p> <p>14 Medicaid.</p> <p>15 Q. You understand an APG to be a similar --</p> <p>16 A. Similar.</p> <p>17 Q. -- concept to an APC?</p> <p>18 A. Yes.</p> <p>19 Q. Did the Hospital Outpatient Department Fee</p> <p>20 Schedule Group give any consideration or devote any</p> <p>21 analysis to changes that were taking place in the</p> <p>22 manner in which Medicare reimburses hospital</p>	<p style="text-align: right;">169</p> <p>1 A. I don't remember who it was.</p> <p>2 Q. Was this a phone conversation or an</p> <p>3 in-person meeting?</p> <p>4 A. Someone came to the Plan and talked to a</p> <p>5 group of us.</p> <p>6 Q. What did the consultant from Treo Systems</p> <p>7 tell you about changes taking place in the way</p> <p>8 Medicare reimbursed hospital outpatient departments</p> <p>9 for drugs administered to patients?</p> <p>10 A. There was nothing specific to drugs. It</p> <p>11 was -- it was a discussion about the methodology of</p> <p>12 grouping services. It was a high-level</p> <p>13 presentation, as I recall, and we didn't pay a</p> <p>14 whole lot of attention to it, because we knew it</p> <p>15 was not feasible from our systems' perspective.</p> <p>16 Q. What was the change that you understood</p> <p>17 Medicare was making?</p> <p>18 A. That it was a prospective payment system</p> <p>19 that was similar to the inpatient DRG methodology</p> <p>20 in that it grouped services together for purposes</p> <p>21 of reimbursement.</p> <p>22 Q. And why -- on what basis did you come to</p>

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<p style="text-align: right;">170</p> <p>1 the conclusion that a similar system could not be 2 implemented at BCBS in relation to services 3 provided in treating patients in hospital 4 outpatient departments? 5 A. I didn't come to the conclusion, but it 6 was communicated to me that our system -- our 7 computer systems could not handle that type of a 8 methodology. 9 Q. Who communicated that to you? 10 A. I don't remember. 11 Q. Now, you testified earlier today that you 12 raised this issue for the first time with Deb 13 Devaux in late 2003, right? 14 A. (Witness nods.) 15 MR. COCO: Objection. 16 Q. Is that correct? 17 A. I raised the -- the issue of the hospital 18 outpatient fee schedule having a lot of services 19 falling into percent-of-charges bucket. 20 Q. Right. 21 A. And that was the -- that was my concern, 22 that there was -- that there was a lot of payment</p>	<p style="text-align: right;">172</p> <p>1 and then, eventually, she felt that the time was 2 right for me to pull together some people to look 3 into it. 4 Q. Now, you said she felt the time was right 5 for you to pull together people to look at it. 6 Were you in charge of the Hospital Outpatient 7 Department Fee Schedule Group? 8 A. It was a collaborative group, and I was 9 partnering with my counterpart -- one of my 10 counterparts in the actuarial department. 11 Q. Well, who was your -- who were you 12 partnering with from the actuarial department? 13 A. Mike Marrone. 14 Q. Did the group have a structure? Was there 15 -- were there people or a person who was in charge 16 of and ultimately responsible for the group's work? 17 A. There was a person that was project 18 managing the group, setting out an agenda, and 19 pulling the people together, scheduling the 20 meetings. 21 Q. Who was the project manager? 22 A. Terrance Driscoll.</p>
<p style="text-align: right;">171</p> <p>1 going through this methodology, percent of charges. 2 Q. Do I understand correctly that this whole 3 process started with you? 4 A. I don't know what happened before I 5 arrived, and I don't know if it started with me. I 6 know that when I came in to Blue Cross and saw the 7 payment methodology for hospital outpatient, I 8 believed that there was an awful lot falling in the 9 percent-of-charges category. 10 Q. When you raised the issue with Ms. Devaux, 11 did she tell you that someone was already working 12 on this or had already looked at this? 13 A. No. 14 Q. Okay. Did Ms. Devaux treat it as a new 15 suggestion or a new idea? 16 A. I don't know if she saw it as a new 17 suggestion, but she -- she considered it to be a 18 valid suggestion. 19 Q. And did she tell you that she would then 20 raise it with others at the company? 21 A. It -- it sort of didn't go anywhere for a 22 little while because of other competing priorities,</p>	<p style="text-align: right;">173</p> <p>1 Q. Forgive me, but I forget, what was his 2 title? 3 A. At the time he was an analyst in the 4 finance department. 5 Q. Was Mr. Driscoll's work -- when you 6 described him as a project manager, was his 7 management role administrative, or was he 8 substantively in charge of the work with the group? 9 A. It was administrative. 10 Q. Who was substantively in charge of the 11 group's work? 12 A. Myself and Mike Marrone. 13 Q. What is Mr. Marrone's title? 14 A. I'm not sure if this is correct, but 15 director of something in the actuarial department 16 -- provider pricing and -- I don't know the -- he's 17 a director of something in actuarial. 18 Q. At the time that you were considering 19 these issues and the Hospital Outpatient Fee 20 Schedule Group was doing its analysis, did you 21 consider that Medicare was also moving to an 22 ASP-based methodology for reimbursing drugs</p>

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<p style="text-align: right;">174</p> <p>1 administered to patients in hospital outpatient 2 departments? 3 A. We became aware of that at the end of our 4 work and after the decision had been made to use 5 the AWP methodology. 6 Q. What -- when did you become aware of that? 7 A. I don't know exactly. It was -- it was 8 somewhere before the implementation in October, but 9 after much of the work had been done to move to 10 AWP. 11 Q. Sometime in the summer or fall -- 12 A. I don't know. 13 Q. -- of 2003? 14 A. I can't -- I wouldn't want to say. I 15 don't know. It's somewhere in -- before we 16 actually implemented. 17 Q. Can you estimate how -- was this a matter 18 of days before October, weeks, or months? 19 A. I would say it was several weeks. 20 Q. How did you become aware of CMS's plans to 21 move to ASP for reimbursement in outpatient 22 departments?</p>	<p style="text-align: right;">176</p> <p>1 Q. Was that issue discussed in the Hospital 2 Outpatient Department Fee Schedule Group? 3 A. It was not formally discussed, because we 4 were so far down the road of implementing the AWP 5 and -- 6 Q. Was there -- were there informal 7 communications about the issue? 8 A. I recall someone, and I don't know who, 9 mentioning that Medicare was changing to the ASP, 10 and -- and I remember thinking that we were so far 11 down the road with our analysis and our 12 implementation, that -- that we wouldn't be 13 considering that. 14 Q. Were there any reasons why BCBS of 15 Massachusetts did not consider following suit with 16 Medicare, other than the stage of the process? 17 MR. COCO: Objection. 18 A. I don't know. When you say, "Blue Cross," 19 that's kind of a big -- 20 Q. Well, I'm happy -- I'm happy to rephrase 21 the question. Are there any reasons why you, as 22 one of the two people in charge of the Hospital</p>
<p style="text-align: right;">175</p> <p>1 A. I don't remember specifically. It could 2 have been something I read or something someone 3 mentioned. I don't remember specifically. 4 Q. Was anyone on the hospital outpatient 5 department financial -- Hospital Outpatient 6 Department Fee Schedule Group tasked with analyzing 7 what Medicare was doing in relation to reimbursing 8 for drugs administered to patients in outpatient 9 departments? 10 A. No. 11 Q. Now, do I recall correctly you said that 12 you may have read about it? 13 A. I may have seen something in a -- in a 14 journal or heard about it from someone internally 15 that may have -- I know I became aware of it and 16 don't remember exactly how. 17 Q. What did you do after you first became 18 aware of the fact that CMS intended to move to 19 ASP-based reimbursement in hospital outpatient 20 departments? 21 MR. COCO: Objection. 22 A. I didn't really do anything.</p>	<p style="text-align: right;">177</p> <p>1 Outpatient Department Fee Schedule Group, did not 2 consider further whether or not to move to ASP, 3 other than the fact that the work of the committee 4 was substantially along? 5 A. My rationale was that -- first, what you 6 said, that we were far along in our process. And 7 secondly, that Blue Cross -- that this was -- this 8 was an incremental move to a new methodology and 9 wasn't intended to cause a lot of alarm in the -- 10 with anyone, and it was simply to move to a 11 standard methodology. This would be the first -- 12 this would be our first, you know, attempt to move 13 to a standard methodology. 14 Q. And if you had followed Medicare in moving 15 to an ASP-based methodology, rather than an 16 AWP-based methodology, would that have caused 17 alarm, to use your phrase? 18 A. I don't know. 19 MR. COCO: Objection. 20 Q. Well, was that a concern? 21 MR. COCO: Objection. 22 A. It was a concern that -- it wasn't a</p>

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<p style="text-align: right;">178</p> <p>1 concern about one versus the other, but using the</p> <p>2 AWP was something that was familiar with everyone,</p> <p>3 myself included, and there didn't seem to be any</p> <p>4 reason to change our direction at that point.</p> <p>5 Q. Well, when you said earlier that -- when I</p> <p>6 had asked what were the rationales for not</p> <p>7 following Medicare, you said one of the reasons was</p> <p>8 not wanting to cause alarm. I'm trying to</p> <p>9 understand what you meant by that.</p> <p>10 A. In my mind, AWP was -- had been around a</p> <p>11 long time and seemed to be accepted, and I didn't</p> <p>12 know what the reaction or what the -- what people</p> <p>13 thought about ASP, because it was so new.</p> <p>14 Q. We've spoken a bit about the Provider</p> <p>15 Financial Strategy Work Group. Have you ever been</p> <p>16 a member of that group?</p> <p>17 A. Yes.</p> <p>18 Q. How long have you been a member of that</p> <p>19 group?</p> <p>20 A. Since I've been an employee of Blue Cross.</p> <p>21 Q. That's since --</p> <p>22 A. 2003.</p>	<p style="text-align: right;">180</p> <p>1 contracting, provider relations.</p> <p>2 Q. Other than Ms. Devaux, Ms. Vertes, and</p> <p>3 yourself, is there anyone else who has been a</p> <p>4 member of the Provider Financial Strategies Work</p> <p>5 Group since 2003?</p> <p>6 A. Tony Centrella, who is a vice president in</p> <p>7 the finance area, and then as people come into</p> <p>8 their roles in the organization that serve a</p> <p>9 certain function, they join the group, or when they</p> <p>10 leave the organization, they leave the group.</p> <p>11 Q. Yeah, I understand that. I'm just trying</p> <p>12 to understand -- get a list of the people who have</p> <p>13 been there steadily since 2003. Is there anyone</p> <p>14 else you can think of who fits that description?</p> <p>15 A. Steve Fox, I think, has been a -- he's the</p> <p>16 director of provider relations. I think he's been</p> <p>17 a consistent member of the group. There are others</p> <p>18 who are consistent members but not -- that don't</p> <p>19 attend consistently, like the sales</p> <p>20 representatives.</p> <p>21 Q. So, you said the total membership's eight</p> <p>22 to ten people, and at least five people have been</p>
<p style="text-align: right;">179</p> <p>1 Q. -- 2003?</p> <p>2 A. Yes.</p> <p>3 Q. Has -- how many people are part of the</p> <p>4 Provider Financial Strategies Work Group?</p> <p>5 A. Oh, I don't know for sure, but in any</p> <p>6 given meeting, there's eight to ten people.</p> <p>7 Q. Since you've been at the company, has the</p> <p>8 membership of the Provider Financial Strategies</p> <p>9 Work Group been relatively stable?</p> <p>10 A. There are certain core people that have</p> <p>11 been stable, and then others have joined or -- or</p> <p>12 stopped coming.</p> <p>13 Q. Who are the core people that have been</p> <p>14 part of the Provider Financial Strategies Work</p> <p>15 Group since you joined the company in 2003?</p> <p>16 A. Uh-huh. It's led by Deb Devaux and Rena</p> <p>17 Vertes.</p> <p>18 Q. What is Ms. Vertes' title?</p> <p>19 A. She's the senior vice president of the --</p> <p>20 or she's the chief actuary, senior vice president.</p> <p>21 And so, they lead the group, and then there are</p> <p>22 representatives from finance and actuary, sales,</p>	<p style="text-align: right;">181</p> <p>1 members of that group consistently since 2003 when</p> <p>2 you first joined the company?</p> <p>3 A. Yes.</p> <p>4 Q. Now, I asked you earlier whether you were</p> <p>5 familiar with Blue Cross Blue Shield of</p> <p>6 Massachusetts' consideration of whether or not to</p> <p>7 move to an ASP-based methodology in the physician</p> <p>8 office setting.</p> <p>9 A. (Witness nods.)</p> <p>10 Q. And I believe your testimony is that</p> <p>11 you're not familiar with that.</p> <p>12 A. Correct.</p> <p>13 Q. Are you aware that that issue was</p> <p>14 discussed -- a subject of consideration -- at</p> <p>15 meeting or meetings of the Provider Financial</p> <p>16 Strategies Work Group?</p> <p>17 A. I was not in attendance at that meeting,</p> <p>18 so I may have missed it.</p> <p>19 Q. Okay. Let me show you a document.</p> <p>20 MR. MANGI: We'll mark this as Exhibit</p> <p>21 Cizauskas 002.</p> <p>22 ("Analysis of CMS Average Wholesale Price</p>

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<p style="text-align: right;">182</p> <p>1 Reform, 2/7/04 marked Exhibit Cizauskas 002.)</p> <p>2 Q. Have you ever seen that document before?</p> <p>3 A. No, not that I recall.</p> <p>4 Q. Take your time --</p> <p>5 A. Yeah.</p> <p>6 Q. -- and familiarize yourself with it.</p> <p>7 A. (Witness reviews document.) No.</p> <p>8 Q. Do you have any recollection -- does that</p> <p>9 -- does reviewing that document refresh your</p> <p>10 recollection as to having participated in any</p> <p>11 discussions with the Provider Financial Strategies</p> <p>12 Work Group assessing whether or not to move to an</p> <p>13 ASP-based methodology?</p> <p>14 A. No, and it talks about the provider --</p> <p>15 "Product and Provider Financial Management." I</p> <p>16 don't know if that's PFSW or not.</p> <p>17 Q. I'll represent to you that there has been</p> <p>18 previous testimony that the PFSW was the group</p> <p>19 analyzing this.</p> <p>20 A. Okay. Uh-huh.</p> <p>21 Q. So, you have no recollection of --</p> <p>22 A. I don't.</p>	<p style="text-align: right;">184</p> <p>1 A. We are analyzing and preparing to update</p> <p>2 the outpatient fee schedule for all of the other</p> <p>3 services that fall into the percent-of-charges</p> <p>4 category and move those, as much as possible, to a</p> <p>5 standard fee schedule.</p> <p>6 Q. What other aspects of the fee schedule are</p> <p>7 you referring to when you say aspects that are</p> <p>8 still on a percent of charge?</p> <p>9 A. Surgeries that had not been slotted into</p> <p>10 fee schedules, some lab codes, other anesthesia,</p> <p>11 recovery room codes, and then there's new codes</p> <p>12 that hadn't been updated. It's been -- it's been a</p> <p>13 long time between updates on the fee schedule, so</p> <p>14 there's a lot of housekeeping cleanup work.</p> <p>15 Q. Now, are you familiar with a product</p> <p>16 called BC 65?</p> <p>17 A. Yes.</p> <p>18 Q. And BC 65 is a managed care Medicare</p> <p>19 product, is that correct?</p> <p>20 A. Correct.</p> <p>21 Q. It's a product wherein Medicare pays BCBS</p> <p>22 of Massachusetts a capitated rate, and then BCBS of</p>
<p style="text-align: right;">183</p> <p>1 Q. -- having discussed that issue. Now, in</p> <p>2 all of the analysis that the Hospital Outpatient</p> <p>3 Fee Schedule Group performed, did it carry out any</p> <p>4 study of what hospitals and hospital outpatient</p> <p>5 departments are paying to acquire drugs?</p> <p>6 A. I'm sorry. Say that again.</p> <p>7 Q. Sure.</p> <p>8 MR. MANGI: Would you mind reading that</p> <p>9 back.</p> <p>10 (Question read back.)</p> <p>11 A. No.</p> <p>12 Q. Was information as to what hospitals are</p> <p>13 paying to acquire drugs at all relevant to the</p> <p>14 analysis you were involved with regarding whether</p> <p>15 or not to move to an AWP-based methodology for</p> <p>16 reimbursement?</p> <p>17 MR. COCO: Objection.</p> <p>18 A. No.</p> <p>19 Q. Is the Hospital Outpatient Department Fee</p> <p>20 Schedule Group still in existence?</p> <p>21 A. Yes.</p> <p>22 Q. What does that group do now?</p>	<p style="text-align: right;">185</p> <p>1 Massachusetts assumes the risk in relation to</p> <p>2 members of that plan, is that a -- is that a fair</p> <p>3 statement?</p> <p>4 A. It would be better if you asked the</p> <p>5 finance people exactly how that works, but to the</p> <p>6 best of my knowledge, that's correct.</p> <p>7 Q. In your present position, are you involved</p> <p>8 with contracting related to the BC 65 product?</p> <p>9 A. For the most part, it's the hospitals and</p> <p>10 negotiating the rate for the hospitals. There</p> <p>11 might be a couple of physician groups that -- most</p> <p>12 of the physician side is through a fee-for-service</p> <p>13 arrangement, and I don't deal with that.</p> <p>14 Q. Do you know whether or not reimbursement</p> <p>15 to physicians under the BC 65 program for drugs</p> <p>16 administered to members in office is currently 95</p> <p>17 percent of AWP?</p> <p>18 A. I don't know.</p> <p>19 Q. Who would know the answer to that</p> <p>20 question?</p> <p>21 A. The finance department, I would imagine --</p> <p>22 Q. Is there a specific individual in the</p>